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As Medicaid Audits of High-Dollar Claims Take Hold, Keep an Eye on Underpayments

Audits of high-dollar Medicaid payments to hospitals may be coming your way. On the heels of successful audits of high-dollar Medicare claims, the HHS Office of Inspector General (OIG) has already worked its way through hospitals in two states and plans to keep rolling.

But hospitals should be on the lookout for underpayments as well, because one of the audits identified a single underpayment that equaled all the overpayments in the state.

"They are replicating a lot of classic Medicare audits on the Medicaid side," says former Texas Inspector General Brian Flood, a managing director with KPMG in Austin. "The theory has always been that [providers] are making the same errors with Medicaid because they have better compliance programs on the Medicare side."

The audits were foretold by the OIG's 2011 work plan and have been yielding a significant error rate. According to the work plan, OIG is targeting "potentially excessive Medicaid payments for inpatient and outpatient services" to institutional providers. The work plan item has produced three reports that identify errors on hospital claims of $200,000 or more in Michigan and Illinois. The findings: Lots of smaller, line-item errors on the high-dollar claims are driving the error rate, similar to the Medicare audit experience.

Hospitals in all states may want to take a closer look at high-dollar Medicaid claims because both OIG and Medicaid integrity contractors (MICs) are interested in this risk area, Flood says. State agencies also may heighten their scrutiny of high-dollar Medicaid payments in response to the OIG audits. Michigan, for example, has pledged to do just that.

It's helpful for hospitals to know what risks cross state lines, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. "Over the years, we've complained a lot about not knowing what to look at in Medicaid. With Medicare, we have OIG compliance-program guidance with risk areas. On the state side, there is not much out there. You have Medicaid manuals, but no clear expectations." New York state is the only exception. The Office of Medicaid Inspector General (OMIG) publishes an annual work plan, similar to the OIG work plan. OMIG lists its audit and investigation targets for the coming year, providing a blueprint for providers' Medicaid compliance monitoring.

The OIG high-dollar audit starts with data mining in the particular state under scrutiny. OIG identifies Medicaid payments of $200,000 or more per case — obvious high-dollar claims — and then determines whether some of the line-items were inappropriately billed. It's a somewhat arbitrary number, but OIG had to draw the line somewhere. Then OIG contacts hospitals that submitted the high-dollar payments in that state. The hospitals are asked to self-audit for the specific high-dollar claims and to determine whether the services were charged correctly.

What's also interesting about these audits is that high-dollar payments are targeted, but the hospital's mistakes are found in lots of lower-cost line items. For example, there may be a line item that should have been billed as one unit of service but was incorrectly billed as 10 or 100 units of service.

Though high-dollar payments may be more common in Medicare, with its older, sicker population, Medicaid has its share of expensive cases. For example, it doesn't take much for babies in neonatal intensive care units to have resource-intensive hospital visits. "It's a much more diverse population," Waltz notes.

Payments Are Based on Inaccurate Charges

The most recent audit stemming from the OIG work plan was released in May. It reported the results of an audit of high-dollar payments for Medicaid services at Michigan hospitals (A-05-09-00095). OIG reviewed 204 high-dollar payments processed by the state Medicaid agency between Jan. 1, 2007, and March 31, 2009. The findings: 25% of the payments for inpatient services "were based on inaccurate charges or inadequate documentation," OIG said. While 151 payments were accurate charges and sufficiently documented, 53 payments were not. What's striking, however, is that one single charge was an underpayment, and it was for about the same amount of money as all the other charges combined. OIG says the 52 inaccu-

rate payments added up to $641,184 in overpayments and one single solitary underpayment was valued at $682,537.

What caused the 52 errors? OIG said:

◆ ***Incorrect charges resulted in 43 incorrect outlier payments;***

◆ ***Incorrect charges resulted in six incorrect percent-of-charge payments;*** and

◆ ***Incorrect diagnosis codes, procedure codes and charges*** caused a combination of three erroneous DRGs and outlier payments.

The sole underpayment stemmed from an incorrect DRG and outlier payment that triggered a lower percent-of-charge payment than the hospital was entitled to. The incorrect payment was the result of the hospital reporting incorrect charges, diagnosis and procedure codes, OIG concluded. "Hospital officials attributed the incorrect charges, and diagnosis and procedure codes primarily to data entry errors," the report states.

Meanwhile, the Medicaid agency in Michigan said it will periodically review high-dollar Medicaid payments to hospitals.

Another audit of high-dollar Medicaid payments for inpatient services was performed in Illinois and the report was issued earlier this year (A-05-09-00049). OIG focused on hospitals with five or more high-dollar payments to the same hospital.

Illinois Medicaid paid about 1.5 million inpatient claims between Jan. 1, 2006, and Sept. 30, 2007. Of them, 286 claims involved payments of $200,000 or more. OIG focused on 224 high-dollar payments that had a total value of $69.7 million.

OIG determined that only 75 services were allowable. The rest of the payments — 149, representing $2,173,482 in overpayments — were problematic. OIG says for 110 payments, hospitals reported inaccurate charges that caused unallowable outlier bonuses. For 39 payments, hospitals reported inaccurate charges that triggered unallowable payments for transplant procedures. Hospital officials attributed the incorrect charges primarily to data entry errors.

In response to the audit, the Illinois Medicaid agency told OIG it would send a letter to hospitals reminding them "of their responsibility to ensure the accuracy of the claims they submit to the department for payment."

Outliers Are Still a Risk

Although they are less of a risk in Medicare in light of CMS payment policy changes, outliers obviously are still a risk in Medicaid. Outliers are payment bumps from Medicare and Medicaid to compensate hospitals for treating resource-intensive patients. "High-dollar claims can result in outliers, which makes the risk even higher," Waltz notes. If the underlying charges aren't warranted, that undermines the outlier claim. But it all depends on the payment methodology in your state.

Despite the scrutiny by auditors and investigators from OIG, state program integrity units/OMIGs, the MICs, Medicaid fraud control units, the Department of Justice and, soon, the Medicaid recovery audit contractors, Flood is worried that providers are unable to give Medicaid compliance the attention it needs. "People were starting to upgrade their compliance programs, but the economy took a dive, and then health care reform was passed, and there are so many competing concerns," he says. "Some compliance programs got frozen in place, so they haven't had the improvement we would have expected."

Meanwhile, MICs and OIG are embracing Medicaid audits of areas that were error-prone in Medicare, Flood says. Along with high-dollar payments, other OIG and MIC audit targets are multiple imaging tests and short stays. Durable medical equipment is also attracting attention on the Medicaid side after being the bane of Medicare watchdogs for years.

To make the most of your resources, Flood recommends coordinating activities inside the health system. He has already seen encouraging signs that this is under way. Case management, compliance, internal audit and finance should work together. "A lot of pieces of the puzzle are starting to talk more to get a better handle on what's going on," Flood says. "It's a nice change to see."

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